To: State Director
SC Dept. of Disabilities and Special Needs
P.O. Box 4706
Columbia, SC 29240

From: Name of Applicant/Service Recipient: _____

DSN Board Name or County of Residence: _____

Name of Legal Guardian, if applicable: _____

Re: Appeal or Request for Reconsideration of an Adverse Decision

This letter is to appeal or request reconsideration of an adverse decision. The applicant/service recipient noted above has been/is:

☐ Denied eligibility for SCDDSN services.
☐ Denied ICF/MR level of care.
☐ Denied Nursing Facility level of care when re-determined.

☐ Denied his/her choice of Home and Community Based (HCB) Waiver service provider.
☐ Denied proper or timely placement on the HCB Waiver waiting list.
☐ Denied, suspended or terminated from a Medicaid (including HCB Waiver) funded service or the amount of service was reduced.
Please specify: _____

☐ In disagreement with the room and board calculations.
☐ Other -please specify: _____

The applicant/service recipient noted above disagrees with the decision because (use additional pages if needed):

_____
_____
_____
_____

The applicant/service recipient noted above requests the following:

_____
_____
_____
_____

Signature: _____ Date: _____

Relationship to Applicant/Service Recipient: _____

☐ Additional records are being submitted for consideration – see enclosure.
☐ Additional records are not being submitted for consideration.